DRAFT

Please type or print.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
Clinical Incident Report

Client's Name:	Date of Birth:	Sex:	MIS #:	Incident Date:	Time:

Provider #	Clinic/Program Name: (Include address if not county-operated)	Incident Location:	Diagnosis:

List the frequency and dosages of all current medications:

Is the treatment regimen within DMH Parameters? Y ☐ N ☐	Treating Psychiatrist:

Clinical Incident Type: (Check number)

☐ 1. Death-Other Than Suspected or Known Medical Cause or Suicide

☐ 2. Death- Suspected or Known Medical Cause

☐*3. Death- Suspected or Known Suicide

☐*4. Suicide Attempt Requiring Emergency Medical Treatment (EMT)

☐*5. Client Sustained Intentional Injury (Not Suicide Attempt) Requiring EMT

☐*6. Client Injured Another Person Who Required EMT

☐*7. Homicide By Client

☐*8. Medication Error or Adverse Medication Event Requiring EMT

☐*9. Suspected Client Abuse by Staff

☐*10. Possibility or Threat of Legal Action

Describe the incident. Include important facts. If necessary, use an additional sheet that includes the disclaimer at the bottom of this page.

Is the family aware of this event? Y☐ N☐	Family Attitude:	Name/Title of Reporting Staff:	Signature:
Telephone #:	Date of Report:	Agency Manager's Name:	Manager's Telephone #:

Mail the report to **Roderick Shaner, MD, LAC DMH Medical Director, 550 so. Vermont Ave., 12th floor, Los Angeles, CA 90020**. within one business day. Make only one other copy to be kept in a separate file at the clinic**. Do not e-mail this report or the Client's name.** *To allow sufficient time for a clinical review of significant events, the Manager's Report of Clinical Review should be completed and mailed within 30 days to the Clinical Risk Manager for asterisked categories 3-10 above. Please call 213-738-4440 for questions. Thank you for reporting.

This information is privileged and confidential under Evidence Code Section 1197 and Government Code 6254 [c.]

Do not file in the client medical record. 7/02

Please type or print LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH MIS: #: _____
DRAFT **MANAGER'S REPORT OF CLINICAL REVIEW**

The Manager should submit this page within 30 days of the clinical incident after completing a clinical review for incidents in asterisked categories 3-10 on the clinical incident report. Mail to Mary Ann O'Donnell, RN, MN, LAC DMH Clinical Risk Manager, 550 South Vermont Ave., 12th Fl. Los Angeles, CA 90020. Thank you for your review of this case.

Manager's Name: _____Manager's Signature:_____ Date: _____
Date of Clinical Incident Report :_____ Check **Y** or **N** if indicated. Please use additional page(s) if needed, referring to the number and include the disclaimer on the bottom of this page to preserve confidentiality. Please attach the Clinical Case Review if conducted. Date and type of last contact:

1. If treatment regimen was outside of DMH parameters, is supportive documentation present in the medical record? **Y**☐ **N**☐ If **N**, please explain.

2. Was substance abuse (SA) a factor in this event **Y**☐ **N** ☐

3. If 2 is Y, was the client receiving SA or Dual Diagnosis treatment? **Y**☐ **N** ☐

4. If 3 is **N**, please explain:

5. If indicated, was this event reported to DHS, State DMH, or DCFS? **Y**☐ **N**☐ If **N**, please explain.

6. List any pre-disposing factor(s) or root cause(s) that may be relevant in this type of event, e.g. include, if relevant, factors in the transfer of care between providers, e.g., medications supplied for transition to the receiving provider:

7. List any recommendations for operational changes or managerial actions that may be considered to lessen the impact or likelihood of this type of event occurring in the future:

8. List any current or new systems, Parameters, Policies & Procedures or Training in your agency or through DMH, that may help your staff deal more effectively with the clinical or other issues inherent in this type of event: